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ABSTRACT

The report describes the Pro-Child Project, a program designed to reduce the incidence of child abuse and neglect in Arlington County, Virginia. Program objectives are noted to include public awareness development, identification and treatment of abusive and neglectful families, and coordination and expansion of community resources. Sections cover a chronological description of the program; model program components (including community and professional education, legislation and policy, and treatment services); evaluation; and conclusions/recommendations. Also included are sample newsletters, program descriptions, letters, forms, and guidelines. (SBH)

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FINAL REPORT

Project Identification Number: 90-C-83 (03)

Project Title - Pro-Child: A Child Abuse and Neglect Program

Project Director/and Name of Person Preparing Report: Marcia W. Moss

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Purpose and Objectives of Project

Original Purpose

Pro-Child had as its prime objective, a reduction in the actual incidence of child abuse and neglect in Arlington County. Pro-Child sought to prevent neglect, abuse, and exploitation of children by "reaching out" to families with coordinated and integrated community services. Efforts were geared toward stabilizing and preserving family life. Concurrently, special emphasis was placed on families whose unresolved problems had produced visible signs of neglect and abuse, or whose home situations presented actual and potentially greater hazards to the physical and emotional well being of children.

Due to staff's goal setting exercise with Berkeley Planning Associates, the original project goals were slightly modified as follows:

1. To develop public awareness of the problem of child abuse and neglect by providing education in the detection, prevention, protection, and care of the abused child; and to develop a knowledge of services available in the community and an understanding of the alternatives to placement of the child.

2. To identify, diagnose, and treat abusive and neglectful families and those in high risk situations with more innovative, effective and efficient methods.

3. To facilitate a more effective coordination and expansion of community resources for the delivery of services to abuse and neglect clients, including better defining respective agency roles.

4. To strengthen family functioning whenever possible and thereby reduce inappropriate placements.

5. To increase the medical community's awareness of suspected abuse/neglect situations, the services available, and thereby increase referrals.

6. To conduct evaluation and follow up studies and participate in research to determine the effectiveness of Pro-Child, and to assess the implications of abuse and neglect on parents and children.

7. To achieve working relationships with four community agencies for the delivery of follow-up services to 25% of the protective services caseload.

Chronological Description of Program

May 1974 - May 1975

Arlington County's protective services unit composed of a supervisor and six social workers, formed the nucleus of Pro-Child, effective May 1, 1974. However, it took approximately two months (5/1/74 - 7/1/74) to reorganize and hire staff, locate new office space, develop new statistical/recording forms.

Pro-Child's Advisory Board members (sixteen) were selected by 7/1/74 and monthly meetings were held beginning 7/18/74. The Board served as an important link between community agencies and a marked increase in referrals to Pro-Child from some of these agencies was noted as a result.

Pro-Child's full staff was hired by 10/74 with the most difficult position to fill being that of half time homemaker. In addition to this homemaker, the grant funded staff consisted of a coordinator, a social worker, a public health nurse, a case aide and a clerk. These positions were added to the existing nucleus of six soical workers, one supervisor and a half time clerk, all of whom were permanent Arlington County employees.

Representatives from the Arlington Juvenile and Domestic Relations Court and from the Arlington Police Department served on Pro-Child Advisory Board. These representatives have been the prime contacts for initiating procedural changes in abuse/neglect referrals to Pro-Child and to the state's reporting system. In addition, Arlington County Schools have established a written policy regarding abuse/neglect reporting. However, with the awareness that insuring proper referrals from agencies is an ongoing process, plans were formulated to work more intensively with the police department. Areas that were covered included education of the police about Pro-Child's services, promotion of earlier identification of abused/neglected children and their families, development of a written referral procedure and coordination of services with the police department where there was concern for a child's safety in his home.

Pro-Child established its own registry of opened and closed cases. Community standards for children in Arlington County were written and distributed to agencies and individuals in order to better determine what constitutes abuse/neglect and appropriate referrals to Pro-Child.

Statistical forms and forms for dictation were devised and evaluative forms from Berkeley Planning Associates were utilized.

Pro-Child continued to include at least 25% preventive cases in its client population. Preventive cases are those situations in which it was hoped Pro-Child intervention would deter abuse/neglect.

Since feedback to the complainant was done primarily by telephone and inconsistently, the need was recognized to devise a more standardized system such as a form letter.

Group counseling became an important service component with four groups, including one for teenagers, operating the first year.

A task force for educating the public was organized, including Pro-Child's nurse as Chairman and selected representatives from the Advisory Board. The task force arranged for distribution of Pro-Child's posters and pamphlets throughout the County. The Lawyers Wives Club and the Women's Junior League volunteered their assistance and took major responsibility for the distribution.

Development of public awareness of the problems of abuse/neglect has included participation in workshops, panels, seminars, lectures, speaking engagements, and newspaper coverage. There were approximately 80 such activities as of March 1, 1975. During the month of March 1975, Pro-Child participated in the American Orthopsychiatric Association's annual meeting as well as making a presentation before the Virginia State Board of Welfare.

Pro-Child did not have its physician on call as anticipated when the original proposal was written. However, a working relationship was established with the Chief of Pediatrics at Arlington Hospital. It appeared that such involvement resulted in increased reporting to Pro-Child by Arlington Hospital.

During the first year Pro-Child responded to approximately one hundred inquiries for information regarding the project and the subject of child abuse/neglect. Virginia's Department of Welfare sent representatives to Pro-Child for a day-long visit to discuss incorporation of aspects of the program into state/local policy programs.

Revised referral forms reporting instances of suspected abuse/neglect to Pro-Child were distributed to the schools, the Juvenile Court, and Department of Human Resouces Intake Services Bureau. Each case received by Pro-Child included such a referral form.

Multi-disciplinary team meetings were held since 7/74. The multi-disciplinary team consisted of a psychiatrist, a psychologist and an attorney who was a County employee. There were three types of team meetings. First, meetings held bimonthly with the entire staff and all the consultants to discuss the most difficult new and ongoing cases. Second, consultants met on alternate weeks with workers to give individual assistance on problem situations and/or to give direct services (psychiatric and psychological evaluations) to clients. Third, the full time staff met weekly to review new cases and determine services and team members' involvement.

The respective roles of the director and coordinator were defined and put into written outline form. Other roles were outlined but within a framework of flexibility. For example, the nurse was available to go with the intake worker on new cases, was available for continual nursing services in situations of medical neglect and worked solely with some families who refused to accept other team members into their homes. The nurse also chaired the educational task force and coordinated speaking engagements and pamphlet/poster distribution.

Volunteers were involved with Pro-Child as parent aides, "friends" to certain children, tutors, babysitters, participation in the day nursery program, distribution of information and fund raising. The parent aide program was not developed as fully as anticipated. It appeared that social workers had difficulty incorporating this aspect into their casework plans. Further attention needed to be directed toward using parent aides.

The family day care program was successfully initiated. Two homes were subsidized at $17.50 per week to be available to Pro-Child children 24 hours a day. These homes were used for emergency placements; For example, when a mother was hospitalized, for parents who were having temporary difficulty coping with their children, to take care of certain children who need extra nurturing and stimulation. In addition, there were three non subsidized homes, including one for teenagers. This home for teenagers provide the parents and teenagers time to "cool off" and deter runaways and foster care placements. A foster home for mother and child was also recruited which helped the mother become a better parent by the foster mother's acting as a role model.

The Way (Wednesday at the Y) was also implemented in the Fall of 1974. This program in cooperation with the Y.M.C.A. offered parents relief from their children (ages infancy - 6) one day per week. It also provided the children a day of activities extra attention and stimulation and the staff a chance to observe children outside their own homes. It was determined that money was better spent on the Way Program and on the family care program than on individual day care slots. By using the above programs, more children were reached and involved in activities outside their own homes.

Psychological evaluations/testing of children and parents were initiated but were limited due to funds. However, the psychologist services were available for crises, and for people who needed specialists help.

The twenty four hour telephone coverage was the most difficult aspect of Pro-Child to implement. Initially there were two plans under consideration. Under the first plan was the prospect of total agency 24 hour coverage into which Pro-Child would be incorporated. The second plan was to have Northern Virginia Hotline answer Pro-Child's after hours calls. Pro-Child's staff would be on call to Hotline. Administrative tie ups prevented the latter plan from going into effect the first year.

The community's and client's awareness of Pro-Child was not yet studied in a systematic way. This plan was partially delayed due to the time involved in having the posters and pamphlets printed. The plan was to direct more attention to this area in the second year.

Pro-Child's first quarterly newsletter was mailed to approximately 65 individuals and agencies during January 1975.

Public Health Clinic staff within DHR participated in learning about Pro-Child. The clinic staff made referrals based on their concerns following interviews for health services.

Goals:

Pro-Child's original prime goal, i.e., a reduction in the actual incidence of abuse and neglect in Arlington was recognized as being unrealistic since that goal could not be measured. However, in relation to this goal, Pro-Child continued to seek to prevent neglect, abuse and exploitation of children by identifying and serving more families in Arlington through intensive outreach efforts, earlier intervention and more effective services. Despite the difference in the interpretation of Pro-Child's prime goal, the objectives established in the original proposal remained unchanged. They required continuing work and emphasis,

especially the objective of reaching the medical community.

Berkeley Planning Associates' goal setting exercise with staff also brought forth some interesting results. Staff concerned with direct services to families placed higher priority on goals such as keeping children with their parents than on the broader range objectives of community condenation, education and public awareness.

Second Year: April 1975 - May 1976

Some of the most significant accomplishments during the second year include:

1. Continuation of a multi-disciplinary team approach to the problem of child abuse and neglect in the areas of identification, diagnosis and treatment.

2. The team received 220 new case referrals between 7/1/75 and 2/1/76 - an increase of 24% over the same time period last year. The increase reflected the community's growing awareness of the Pro-Child program and willingness to make referrals.

3. Implementation of a 24 hour seven day a week response capacity to child abuse/neglect complaints and establishment of a centralized intake service.

4. An increase in direct services provided to children and renewed emphasis on the provision of preventive services to high-risk families.

5. Only 2.9% of all children that Pro-Child identified as being abused/neglected were placed outside their own homes in agency foster care.

6. Participation in three research projects studying various aspects of the child abuse/neglect problem in addition to continued participation in Berkeley Planning Associates' evaluation.

7. Numerous speaking engagements, including assistance to other communities interested in establishing child abuse/neglect programs and provision of training for professionals.

Pro-Child had well established itself as the agency in Arlington to evaluate complaints of child abuse/neglect, as evidenced by increasing number of referrals to the project.

Pro-Child's Advisory Board continued to meet on a monthly basis and was representative of 14 agencies and concerned individuals. The Board gained momentum during the second year by eliciting its own co-chairman (Director of Social Services, Arlington Hospital). It thus established itself as an independent body that could have separate impact on the services Arlington provided to children who were abused/neglected.

There were a number of staff changes. The Director retired on 7/31/75 and was replaced by Coordinator Cynthia Ragan. The Pro-Child Intake Social Worker resigned and was replaced by a Spanish speaking intake worker. The additional intake social worker position sought in the previous years proposal was filled, bringing the staff to a total of 8 social workers (2 intake workers and 6 workers to handle ongoing cases). Pro-Child's clerk typist resigned and was

replaced. In January 1976, Arlington County provided Pro-Child with a much needed additional clerk-typist. The homemaker position which was expanded to a full time position was vacated twice during this time period but filled permanently in April 1976.

The Way Nursery program expanded to a two day a week program in September 1975. Pro-Child hired a director and an aide for the program. The Clarendon United Methodist Church donated the facilities and handled the administrative details. The aide was hired from the Pro-Child client population.

The range of consultants grew with the addition of a pediatrician who was the Chief of School Health Services and an education specialist from the Arlington County Public Schools.

Pro-Child also contracted with an Art therapist who worked directly with children and a family systems consultant who provided training to the staff.

Pro-Child's own staff represented a diversity of specialties such as group counseling, family systems counseling, behavior modification. This diversity provided Pro-Child with the opportunity to provide a range of treatment modalities best suited to the needs of the clients.

As far as Pro-Child was aware, the Juvenile Court and Police Department were referring all cases of abuse/neglect that came to their attention to Pro-Child for assessment and provision of services. This system was reinforced by the child abuse/neglect law passed by the Virginia Assembly (effective 7/1/75) that mandated such referrals to the local division of social services.

In addition, Pro-Child continued to provide education to the Juvenile Court Probation Counselors and to the Police Department officers. The latter was accomplished by the police department's representative on the Advisory Board attending "roll call" for the three police shifts and explaining Pro-Child's referral system and program. Newly hired police officers were routinely educated during their orientation to the County's resources.

In addition to a registry of Pro-Child's clients maintained within the unit, Pro-Child's cases were registered with a Central Registry established on 7/1/75 in the State Department of Welfare, Richmond, Virginia. All social services divisions in Virginia were required by the 1975 Child Abuse Law to register their protective services complaints and send follow up reports on each complaint.

Pro-Child supplemented its list of community standards with referral guidelines. These guidelines were distributed to all likely referring agencies. The guidelines also provide a definition of abuse/neglect and assist in setting priorities for intervention.

Pro-Child's own abuse/neglect referral forms were largely replaced by those necessary to meet the States and Central Registry requirements. Once, Pro-Child established and expanded its own direct intake system, referral forms were completed by the intake worker as she gathered information during the telephone call or office visit. Pro-Child preferred not to burden other agencies with such forms as it seemed that the less cumbersome the referral process the more apt these agencies are to make referrals.

Pro-Child sent "feedback" letters to the complainant on a routine basis. Letters were also sent to families where abuse/neglec was not validated.

Pro-Child began in 10/75 to check with the Health Services Division, Mental Health Clinic and the School Health Division as to their knowledge of families referred. This process served as a means of identifying mutually known families so that coordinated services could be initiated early in the treatment plan.

The nurse for Pro-Child continued to act as a chairperson for the community education task force. She screened all requests for speakers and recruited staff to meet the requests. In addition, she coordinated the distribution of Pro-Child's pamphlets and posters in the community. Volunteer groups were used to do the actual distributing.

Pro-Child continued to be available to the community for speaking engagements and meetings with interested/concerned individuals. Such requests occurred almost daily and left little time ot initiate public/professional education. The following are highlights of the educational efforts.

1. Pro-Child conducted an all day institute in October 1975, for the Virginia Councel on Social Welfare. This institute emphasized different treatment modalities used by the Pro-Child staff.

2. The Virginia League of Executive Directors requested a Pro-Child speaker to present Pro-Child's service delivery systems. The audience of 140 included the State Board of Welfare, social services directors, supervisors and other administrators. The purpose of the discussion was to help other Counties in Virginia implement similar child abuse/neglect programs.

3. Pro-Child was asked to give its imput to Washington, D. C.'s DHR.

4. The influx of Cambodian and Vietnamese refugees into Arlington County resulted in the need for a program to educate these families regarding what was considered to be child abuse/neglect. Abuse/Neglect referrals on such families to date have illustrated marked difference in child-rearing practices, some of which Pro-Child considered to be abusive. A program of education was implemented in conjunction with the Arlington County Career Center. The Career Center provides training for large numbers of these families.

5. One of Pro-Child's former clients has become the leader of the Northern Virginia Parents Anonymous Groups. She, in turn has been on television and radio shows advocating both Pro-Child and Parents Anonymous.

Pro-Child's consulting pediatrician has provided direct physical examinations on children referred by Pro-Child. Pro-Child's relationship with the Chief of Pediatrics at Arlington Hospital resulted in a plan to establish a hospital protocal on child abuse/neglect cases, including a specialized team to evaluate cases.

The psychologist no longer regularly participated in the large staffings as in the first year but was available, as needed, for individual consultation and psychological evaluations. This change was partially circumstantial due to a

switch in the psychologist's work schedules, but it also reduced a duplication of expertise at staffings, and the educational specialist was also a psychologist.

The establishment of team roles continued to be an ongoing process with emphasis on clarification of the homemaker and case aide positions. Individual staff members' special interests and expertise were considered important in assignment of tasks and created flexibility in role definition.

Pro-Child developed a total of five family support homes that provide emergency babysitting relief to families in crisis. The families were willing to be available to Pro-Child without a contingency fee for keeping beds available. Pro-Child continued to pay these families for the actual care of children. One of these families was willing to extend itself to a mother and child in need of shelter. These family support homes were regarded as one of the most important services. Availability of these homes have prevented many children from being placed in foster care.

Pro-Child continued to train new sets of volunteer parent aides to work directly with families. As Pro-Child staff began to see the value of the use of these volunteers, they were used more readily by the staff. Workers who used the parent aides one time and had a good experience requested them more frequently than workers who had never used them.

Twenty four hour coverage to receive and to respond to child abuse/neglect complaints was finalized by the establishment of a contract with Norther Virginia Hotline. Pro-Child switches its "reporting telephone line" over to the Hotline office after hours and on weekends. A trained Hotline Volunteer answers this line "Pro-Child," gets certain crucial information from the complainant, and in turn contacts the social worker on call by telephone or by bellboy. The emergency number was also used for certain high risk clients to reach their social workers after office hours and on weekends. Pro-Child paid Hotline $75.00 per month out of H.E.W. funds for the provision of this service. Department of Human Resources Representatives planned to negotiate a contract with Hotline that would eliminate Pro-Child's share of the expense.

Questionnaires were distributed to agencies assessing their awareness of Pro-Child and their satisfaction or lack of satisfaction with the program.

The Way program continued to use Pro-Child's parents as day care aides/volunteers and also encouraged other parents to visit the program. In December, parents were invited to the Way Program's Christmas Party.

Project staff continued to respond to all community and professional educational requests. Several lectures were provided to High School students by Pro-Child staff.

Pro-Child was viewed as a functional unit within the agency and within the community. Pro-Child continued to overcome the stigma attached to the field of protective services and to establish itself as a unit that was responsive to children, parents and the community.

Third Year: May 1976 - June 1977

A major activity the third year was developing funding to continue the project beyond May 1977. Concurrently, some planning was done to prepare for the possible cut back in the program. Major staff turnover including the project director, five social workers, the nurse and the clerk occurred during the third year. Most of these resignations were due to the uncertain future of the program. Staff members in grant funded positions sought other permanent positions. However, new personnel were quickly hired and the program was able to continue without serious disruption in activities. The new personnel was hired on a temporary basis because of the uncertainty of funding beyond the federal grant period. There was some shifting in the staff to disperse the responsibility for intake. Because of the increasing number of cases and the demanding crisis oriented nature of intake work, the number of workers assigned to intake was increased from 2 - 3. The shift meant that 5 workers instead of 6 were now assigned to ongoing but it was decided that they could absorb the additional cases rather than overburden the intake workers.

The project's family support homes and the consulting psychiatrist were approved as Title XX Vendors. In December 1976 the project presented a proposal to the County Board of Supervisors and received local funds to continue the seven grant funded positions through June 30, 1977. The state also gave approval for funding the state's share of the positions until June 30, 1977.

Funding for the program after June 30 was still uncertain and was related to the total agency budget process for fiscal year 1978.

In February 1977, the project's staff psychiatrist was unable to continue because of a cutback in the agency's title XX funds. A clinical psychologists employed at Arlington County's Diagnostic and Evaluation Center agreed to become a regular member of the team and serve as the psychological consultant. The multi-disciplinary team was able to continue fully staffed. However, meetings were held only once a month, rather than twice a month as before. The psychologist was only able to arrange to come once a month and the other team and staff members felt that monthly meetings would be sufficient to maintain the concept and the services. The staff was also free to contact each consultant for individual conferences if needed.

The Way Program (Crisis Nursery) was discontinued on March 31, 1977 because H.E.W. funds were becoming depleted and there was no other possible funding base. Since the program had been licensed as a "mothers day out program" and did not meet the technicalities of the current day care licensing standards, it could not be licensed as a Title XX Vendor. Therefore, there was no possibility of using Title XX funds. When the Way program closed, the children were referred to other Day Care Centers in Arlington.

Since the Way Program closed in March, the project has been making efforts to establish the concept of a crisis nursery elsewhere. One major effort has been directed at coordinating services with the Growth and Development Center, another program sponsored by the Arlington County Department of Human Resources. The Growth and Development Center is a program which offers supportive and therapeutic intervention to pre-school children with developmental and emotional disabilities.

They are staffed with specially trained personnel and consultants to provide services to children and parents. The potential of funding through Title XX or private funding were considered as good possibilities. However, the plan had to be abandoned because of a space problem at the Growth and Development Center.

The project continued to use existing day care facilities. Future plans were to explore other facilities for space for the program. Another possibility is purchase of several spaces in existing day care programs which could be used on a regular and crisis basis. Other efforts will be directed at establishing a Pro-Child Day Care Home which would be equipped to handle several children on short notice.

In April 1977, Pro-Child was given the opportunity to make a presentation to the State Commissioner of Welfare when he was in Arlington for the Title XX Hearings. The meeting was an informal, spontaneous, effective session in which advocates of Pro-Child told the Commissioner about their experiences with the program and why they thought it should be continued. Speaking on behalf of the program were a school health nursing supervisor, a detective from the Youth Section of the Police Department, a visiting teacher from the Public School System, a pediatrician, a private citizen, two mothers who were Pro-Child clients and one teenager who was a Pro-Child client.

In addition to support for this presentation to the Commissioner, the Pro-Child Advisory Board was extremely helpful in mobilizing support for the program's continuance from their respective agencies. Representatives of agencies as well as individuals wrote letters to the Commissioner and the County Board in support of the program's continuance.

At the County Budget Hearing in April, the County gave approval to the Social Services Division for three permanent social work positions and one permanent case aide position. These positions were to be utilized for the prevention of child placement, whenever possible, and in the related development of community based resources. Two of these social work positions and the case aide position were allocated to Pro-Child. In addition, the supervisor/coordinator who was in a grant funded position was made a permanent employee by upgrading a social worker slot. In July, the State gave final written approval for the state share of the four positions approved by the County in April. Therefore, the project was able to maintain four of the seven positions previously funded by the H.E.W. grant.

The following positions were maintained:

1. Supervisor Coordinator
2. Two Social Workers
3. Case Aide

The following positions were deleted:

1. Homemaker
2. Nurse
3. Clerk

With the maintenance of four key positions, the program should be able to continue with very little disruption. The most meaningful losses are the loss of transportation and other concrete services provided by the homemaker, and the consistent availability of nursing services for emergencies and intake referrals.

The clerical services can be dispersed to some degree to other agency clerks. There is a possibility that Homemaker Services will be possible through Title XX Purchase.

The staff is using the regular Public Health Nurses and plans are underway to work out procedures with Public Health for emergency referrals.

Pro-Child will be able to maintain family support homes through use of foster care and Title XX funds.

Some of the new accomplishments the third year include.

1. Presentation on child abuse for Arlington Hospital Staff and Community people conducted jointly with Child Protection Center in D.C.

2. Establishment of group for Spanish speaking mothers.

3. Pilot study on client's perception of Pro-Child's services, conducted by students as part of field placement in Pro-Child and supervised by Pro-Child worker.

4. Establishing guidelines with Juvenile Court, Mental Health Clinic, Catholic Family and Children's Services, and Northern Virginia Family Services for mutual referrals of children formerly handled in the courts as status offenders.

5. Expanding responsibility to all agency child welfare social workers for 24 hour after hours duty. The Pro-Child staff is no longer solely responsible for after hours coverage.

6. Receiving an award from State office of Volunteerism for effective use of volunteers.

7. Completing a contract through agency administrators to pay Northern Virginia Hotline for answering Pro-Child's phones.

APPENDIX A

MODEL PROGRAM COMPONENTS

A. Community Education

B. Professional Education

C. Coordination

D. Legislation and Policy

E. Research

F. Treatment Services

1. Case Management and Regular Review
2. Court Case Activities
3. Psychological Testing
4. Multidisciplinary Team Review
5. Individual Therapy and Counseling
6. Group Therapy
7. Day Care
8. Family Support Homes
9. Play Therapy
10. Homemaking Services
11. Medical Care
12. Transportation
13. Financial Support

MODEL PROGRAM COMPONENTS

A. Community Education

In addition to providing direct services to clients, all Pro-Child staff have been involved in providing educational presentations for the community. These presentations are directed at helping citizens become more aware of the dynamics of child abuse and neglect, their reporting responsibilities, and the resources that are available in the community to combat this problem.

Pro-Child staff have been interviewed for newspaper and magazine articles, appeared on local television and radio shows, distributed posters and pamphlets through the county and given presentations to many groups, including service clubs, students and auxiliaries.

B. Professional Education

In order to acquaint local professionals with the problems of child abuse and neglect, the Virginia Code requirements related to abuse and neglect and the services available from Pro-Child and other agencies, the project staff have held meetings, training sessions, and interviews with a wide variety of community agencies.

Most of these efforts have been aimed at professionals who are apt to come in direct contact with abuse/neglect situations, including personnel in the schools, the Juvenile and Domestic Relations Court, and hospitals, as well as police and private physicians. In addition, professionals in other direct service agencies, including staff of the Division of Social Services, have received some educational material from Pro-Child.

C. Coordination

Efforts to develop a more coordinated community system, one of the goals of the project, hinge both on the educational efforts described above and on extensive coordination activities with community agencies.

Prior to passage of the new state law in early March 1975, the project's attempts at coordination were primarily in the area of centralizing reporting so that one agency, instead of three, would have responsibility for receiving and investigating all reports of abuse and neglect. Agreements were reached with both the police and the Court that all abuse and neglect reports would be forwarded immediately to Pro-Child for investigation. The Virginia Code now makes this reporting procedure mandatory.

Written referral procedures and forms were distributed to other community agencies to promote easy referral to Pro-Child. The forms are being used by many agencies and there has been a noticable increase in reporting from these sources.

Attempts to coordinate service delivery include developing procedures for referrals and follow-up between service delivery agencies, and joint consultation on individual cases whenever necessary.

D. Legislation and Policy

During its first year, staff of Pro-Child worked with state legislators and other agency personnel to draft a new child abuse and neglect law in Virginia. The new law, Title 63.1, passed in March 1975, designates the local department of welfare (Pro-Child) as the sole agency to receive reports. It broadens the definition of abuse and neglect, provides penalties for failure to report and mandates 24 hour reporting and investigation coverage, the use of Multidisciplinary Teams, and the establishment of a state Central Registry. Each of these provisions was supported by Pro-Child, and the Multidiciplinary Team approach was patterned, in part, after Pro-Child's program. The Project Director and Coordinator have been involved in the statewide tadk forces responsible for devising regulations to implement the law and are planning to sponsor a workshop for Arlington agencies to acquaint professionals with the new regulations.

E. Research

The evaluation efforts of the project have included the development of monthly statistical summaries of all cases, logs of client contacts, and other record-keeping procedures required by the Department or the state agency, as well as cooperation with all BPA evaluation procedures.

Additional research efforts include the following:

(a). an analysis of referral sources to determine the effectiveness of Pro-Child's educational efforts;

(b). analysis of client success and recidivism rates;

(c). a survey of clients to determine their impressions about the project and the services they received;

(d). participation in a research study by a professor of social work and students to test maternal attitudes of Pro-Child clients;

(e). participation in a research study by a graduate student to assess the impulse control of Pro-Child clients.

F. Treatment Services

1. Case Management and Regular Review: Each of the social workers on the staff provides general casework services for all clients in his or her caseload (approximately 25 per staff member) either individually or as a team with other staff members. Home visits, telephone calls, and office visits are all used to maintain close contact with clients.

The workers provide a supportive, non-judgmental framework for discussing the families' problems and attempting to resolve them. In the course of this casework, they assess the needs of the family and provide, either directly or through referral to other agencies, the services required. Agencies in Arlington that provide supplementary financial assistance, clothing, food, transportation, legal aid, etc., are used as referral sources by Pro-Child workers. In addition, many services are available through other units of the Division of Social Services,

e.g., AFDC assistance and public health clinics, including well-baby, dental, mental health, child diagnostic and evaluation, growth and development, alcoholic and drug abuse clinics. Referrals for other health, mental health or psychiatric evaluation and treatment are made to a variety of public and private agencies. Follow up on these referrals is usually provided.

Each worker reviews his or her ongoing cases at least once every three months. At this time the client's progress is assessed, any new problems are explored, and if warranted, new goals and treatment plans for the client are established. Pertinent additional information is also entered into the client's record at that time. Less formal, ongoing review of cases takes place with each worker's supervisor on an as-needed basis.

2. Court Case Activities: Staff social workers who are faced with the need to present a case in court are given legal counsel by the lawyer who is a member of the Multidisciplinary Team. The County Attorney's Office has donated 20% of this lawyer's time to the project.

The social workers prepare the necessary petitions with assistance from the lawyer, explain all of the proceedings to the parents and child, and appear in court to testify and make recommendations about disposition of the case. They then provide the necessary assistance in implementing whatever decision has been reached by the court. If a case requires foster care services, Pro-Child usually continues to work with the family while the child is in care, in order to effect early family

3. Psychological Testing: Psychological testing of both adults and children is provided by the psychologist who serves as a consultant to the project and is a member of the Multidisciplinary Team. His interpretation of the tests administered is aided by his thorough knowledge of the types of cases Pro-Child deals with. His continuing availability to workers for consultation helps provide more appropriate treatment planning.

4. Mulitdisciplinary Team Review: Multidisciplinary Team reviews of complex or problem cases are held on a bi-weekly basis. Two cases a session are usually reviewed with all staff and consultants, including a pediatrician, psychiatrist, psychologist, lawyer and a school representative. In addition, other professionals who have direct knowledge of a case, for example, a Public Health Nurse of School Social Worker, are often asked to attend these meetings. The meetings are held both to enable an individual worker to better deal with a specific case and to provide continuing education and exposure to a variety of problems for the remainder of the staff.

5. Individual Therapy and Counseling: The treatment mode most frequently used by Pro-Child staff, either alone or in conjunction with other services, is individual therapy or counseling. Through this technique, the staff attempts to engage clients in a dialogue that permits the client to explore his or her feelings about problems he or she is encountering, to analyze various solutions to the problems, and to choose a course of action suited to achieving his or her desired goals. This counseling usually takes place in the client's home or the Pro-Child offices, as often as necessary, and is not limited to strict "appointment" times. The counseling tends to be intensive when a client first enters

the project and around crisis periods, and gradually tapers off as a client become more able to cope with their problem.

6. Group Therapy: Three staff members co-lead group therapy sessions for many Pro-Child clients. There are currently afternoon and evening mother's groups and an adolescent group; each has approximately 10 participants. Two of the social workers are also jointly offering family therapy sessions for a few of their clients and this component may be expanded if it appears effective over time.

7. Day Care: During its first year, Pro-Child provided day care for up to 15 children one day a week through a contract with the local YMCA. The primary purpose of the Way program (Wednesday at the Y) was to give the parents some relief from their daily child care responsibilities and to provide an opportunity to assess the developmental difficulties of the children. The children were provided with a variety of learning experiences, went on field trips and had structured play time. The Y also has a Saturday activities program for children which is free for Pro-Child clients.

The Way program has been discontinued, but the project is currently negotiating with another church affiliated organization to provide the same type of a day care for an expanded number of children.

8. Special Family Care Homes: Pro-Child has four Special Family Care homes for the temporary day and overnight care of children. Three of these homes take children of all ages for short periods and one home works only with adolescents. One of the homes for younger children is subsidized by Pro-Child, so that there is always at least one slot held open for real emergencies. The other homes are reimbursed, based on the number of days and nights a child is in care. These homes are particularly appropriate for situations where brief child care is needed, e.g., a family crisis requiring a "cooling down" period or a temporary hospitalization. The only alternative would be foster care, which tends to involve temporary loss of custody and is a threatening experience for parents.

9. Play Therapy: An Art Therapy class for up to six children is provided once a week by a trained art therapist. These classes provide a mechanism for the improved diagnosis of children's psychological problems and provide the children with an acceptable way of expressing themselves.

10. Homemaking Services: Homemaking services, including assistance in houshold management, budget preparation, and nutrition counseling are provided for many clients by the projects's Homemaker.

11. Medical Care: The Public Health Nurse who is a member of the staff does medical screening and provides nursing services and routine medical services for parents and children when required. In addition, many other forms of medical care are available to Pro-Child clients through clinics and special programs operated by the Department of Human Resources.

12. Transportation: County cars are available to the Case Aides and other staff to provide clients with transportation to shopping areas, medical and other appointments, Pro-Child activities, and the day care program. In addition, the three staff members providing group therapy supply participants with transportation to and from these sessions.

13. Financial Support: A modest amount of money is available, partly through the grant and partly from private donations, to make small loans to clients in a financial crisis. Food, clothing, and other supplies are also given to clients who are in need.

EVALUATION

Project Goals

The Pro-Child project has made significant progress towards accomplishment of each of the goals articulated by staff as high priority during the demonstration period. New and innovative services for abusive and neglectful parents and their children have been provided to approximately 400 cases per year by project staff. Educational programs have been presented to nearly every identified agency in the county involved or potentially involved in the child abuse and neglect problem. As a result of these educational presentations and additional coordinative efforts, and strengthened by new Virginia legislation, a more comprehensive and integrated system for dealing with all phases of the problem, from identification through reporting, case management, treatment and follow-up, has emerged in Arlington. Because the project is housed within the local protective services agency, it appears likely that many of the positive gains achieved by Pro-Child will be of a lasting nature, since this agency is a permanent component of the state Department of Human Resources (one exception may be the discontinuation of various new service components due to lack of funds).

The specific accomplishments made by the project toward achieving its high priority goals are as follows:

> Goal 1: To develop public awareness of the problem of child abuse and neglect by providing education in the detection, prevention, protection and care of the abused child, and to develop a knowledge of services available in the community and an understanding of the alternatives to placement of the child.

The project has made very significant efforts to educate both the lay and professional citizens as to the etiology of child abuse and neglect and the current Virginia law related to suspected cases, and to instill non-punitive, therapeutic attitudes toward people experiencing this problem. Project staff have surpassed their targeted figures for these educational efforts. In fiscal year 1976 alone, the staff gave over 133 written and oral presentations, reaching an estimated 2100 professionals and non-professionals in Arlington. The people receiving education represent the Arlington community, other divisions of the Department of Human Resources, schools, courts, hospitals, military and other public and private agencies.

Professionals reached via educational efforts included social workers, physicians, teacher, probation officers, nurses, police, counselors, school principals and lawyers. The non-professionals included day care providers, students, volunteers, members of civic and service clubs, and general citizens.

Although the project has not conducted an overall evaluation of the extent to which the education has increased the knowledge and awareness regarding child abuse and neglect of those reached, some assessments have been made. Questionnaires to determine knowledge and attitude changes were distributed to members of the Advisory Board and 57 people in their respective agencies. All of these people responded that they were more knowledgeable about the problem of child abuse/neglect and were more aware of the appropriate procedures to follow if the problem was suspected than they had been prior to the education received from the Pro-Child staff. Similarly, a group of 45 people at a meeting of the Virginia Council of Social Workers responded unanimously that the presentations by project staff had increased their knowledge and awareness. In

addition to these assessments, positive responses to queries regarding increased knowledge and awareness were received from the personnel in each of the five key agencies (police, schools, courts, hospitals and juvenile courts) and community personnel when interviewed by a member of the Berkeley Planning Associates staff. These respondents additionally volunteered that Pro-Child was the single agency in the county responsible for the educational efforts related to child abuse and neglect currently ongoing.

Another measure of the positive outcome of this education is the increase in referrals to the project from sources who have received some contact and previously referred infrequently. As of fiscal year 1976, these increases were 300 percent from hospitals, 235 percent from schools, and 300 percent from physicians, all substantial increases. As a proportion of total referrals, however, hospitals have only increased from two percent in fiscal year 1974 to five percent in fiscal year 1976, and private physicians, who reported one percent of the total cases in fiscal year 1974 reported just two percent in fiscal year 1976. The schools, in contrast, have shown a marked increase, having reported only nine percent of all cases in fiscal year 1974, and reporting 19% of all cases in both fiscal years 1975 and 1976. Each of these sources of referrals also appear quite knowledgeable regarding the types of situations appropriate for referrals to the project. One hundred percent of the referrals from hospitals and physicians, and 70% of the referrals from school personnel are valid upon investigation.

Goal 2: To identify, diagnose and treat abusive and neglectful families and those in high risk situations with more innovative, effective and efficient methods.

One of the major aims of the Pro-Child project was to be able to provide a variety of services that were more appropriate for abuse and neglect clients than was previously possible under the protective services agency program. The services which have been developed to date include 24-hour hotline services for reporting cases, an intake process for abuse and neglect cases which is separate from the more bureaucratic DHR intake procedure, multidisciplinary team review of particularly severe or problematic cases, group counseling for mothers, couples, families, adolescent girls and alcoholics, homemakiking services, medical care provided by a nurse who is part of the staff, a two-day a week day care program for children, two play therapy groups, an art therapy group, and a socialization group for children, and five temporary shelter homes to be used by clients during time of crisis. Obviously, not all clients are able to effectively use all of these innovative services, but it appears that most clien have made use of one or more of these new services in addition to receiving the more traditional individual counseling and supportive services.

At the current time, it is difficult to assess the actual effectiveness of these services, as data from the BPA evaluation has not yet been completely analyzed. It appears, however, that in fiscal year 1976, in about 70% of the cases terminated so far, the reason for termination was that the primary caseworker judged the case to be ready for closure. The remainder of the cases which could be considered "unsuccessfully" closed were terminated for the following reasons: complaint not valid (9%), client unable to be contacted (3.5%), client refused services (3.5%), and family moved while receiving services (12%). The recidivism rate (based on the percentage of new reports which were for families previously open to the project) has dropped from 12.6% in fiscal year 1975 to 6.5% in fiscal year 1976.

Goal 3: To facilitate a more effective coordination and expansion of community resources for the delivery of services to abuse and neglect clients, including better defining respective agency roles.

The Pro-Child project has made many positive gains toward coordinating the community system for dealing with child abuse and neglect, and everyone surveyed by BPA staff agrees that the changes implemented by the project, and then strengthened by state law, have resulted in a more efficient and effective system.

Coordinative contacts have been made with and referral guidelines and reports sent to personnel in the courts, schools, District Attorney's office, police, all DHR units, hospitals, Head Start programs, Arlington Hotline, mental health clinic, Junior League, Northern Virginia Services League, YMCA, state delegates, Recreation Department, and the Northern Virginia Family Services agency. These agencies and institutions include all those in Arlington who could reasonably be defined as potentially involved in child abuse and neglect problems.

Pro-Child has used its 13 member Advisory Board as the primary education and coordination agent between its program and the agencies represented on the Board. Other mechanisms for ongoing communication and coordination between agencies include providing feedback to complainants on the status of cases they have referred, inviting personnel from other agencies who are familiar with a Pro-Child case to participate in the case conference or multidisciplinary team review of that case, and maintaining informal contact with the agencies referring cases about progress of the case throughout the treatment process.

Both the coordinative efforts of Pro-Child and the new Virginia law which centralizes the reporting system for abuse and neglect have reduced most of the duplication in the community system. It appears that all agencies save one are now reporting cases directly to Pro-Child for investigation and treatment planning. In the case of the juvenile court, both a review of cases reviewed by the court, and interviews with personnel there have indicated that some percentage of abuse and neglect cases (albeit small) are still being handled directly by the court staff rather than being reported to Pro-Child.

The outcomes of the coordination efforts undertaken by Pro-Child have been positive, markedly improving the efficiency and effectiveness of the system to deal with reported cases; the reporting, investigative and treatment duplication which plagued the system prior to fiscal year 1974 have been eliminated. However, with respect to expanding community resources available for these clients, only the project services developed under the new grant have in any way expanded Arlington's resource base, and there are some easily identifiable gaps in the community system which, so far, the project has bot been able to remedy. As in many communities, there is a lack of adequate foster homes, especially homes appropriate for use by Pro-Child. Psychiatric services for children and programs for adolescents are almost totally unavailable for these clients. There is little, if any, outreach into the community by Pro-Child or any other agency. Homemaking services are vary scarce, although Pro-Child has a homemaker on its staff for abuse and neglect clients, and there are few community agencies or groups with funds to provide emergency financial assistance. Finally, there is a lack of appropriate services for cases of sexual abuse.

Goal 4: To strengthen family functioning wherever possible and thereby reduce inappropriate placements.

Ten new services have been developed specifically to strengthen family functioning, including: group counseling, family therapy, day care for children, family support homes, 24-hour hotline services, medical care, homemaking services, case aide transportation, volunteer aides to families, and consultation services to other agencies dealing with abusive and neglectful parents and their children. About 80% of the current caseload are receiving these services.

Pro-Child has also developed an agreement with the Foster Care Unit of DHR which is a major step toward ensuring that reunification of families wherever feasible is the primary emphasis of treating both children and parents. Under this agreement, when a child requires placement in foster care, but Pro-Child perceives this placement will be necessary for only six months or less, the Pro-Child worker on the case remains the primary caseworker for that case, rather than a foster care worker. In this way, the child can be protected, but parents continue to receive the treatment they need to enable them to care for their children in the future. Decisions as to return of children in foster care are made jointly by the Pro-Child staff member working with the parents and the foster case worker assigned to the child. It is estimated that this agreement is being met in over 85% of the cases requiring foster care.

Although there are no criteria at present to measure "inappropriate" placements in foster care, there has been a significant overall reduction in foster care placements. In fiscal year 1976 and a projected 3.0% of the total caseload of 1,329 children in fiscal year 1976 and a projected 3.0% of the total caseload in fiscal year 1977. Only 12% of the children placed in foster care in fiscal year 1974 were returned home during that same year, while 49% in fiscal year 1975 and 55% in fiscal year 1976 were returned within one year of placement.

Goal 5: To increase the medical community's awareness of suspected abuse/neglect situations, the services available, and thereby increase referrals.

Steps taken to achieve this goal included presentations to physicians, nurses and auxiliary medical personnel in public and private agencies and hospitals, and distribution of informational packets to medical personnel in the community.

In addition, medical personnel are involved in both the Advisory Board and the multidisciplinary team, and other project components. A pediatrician who is the director of school health programs, and a psychologist participate on the multidisciplinary team. There was one nurse who was a staff member of the project, providing medical supervision for clients requiring it, and other public health nurses make joint visits with Pro-Child staff on over 20% of the home visits and participate in case conferences as appropriate.

Despite these attempts to involve the medical community, an examination of the referrals do not reflect any significant increase in referrals from these sources. Referrals from hospitals have increased from 2% in the year before the project began to 5% during fiscal year 1976, and referrals from private physicians have risen from 1% to 2% of total referrals in the same two years, neither change being as large as desired. While it is clear that the medical input into project operation has been significant, it appears that the educational efforts designed to encourage more reporting from medical sources have not been successful to date.

Goal 6: To conduct evaluation and follow-up studies and participate in research to determine the effectiveness of Pro-Child, and to assess the implications of abuse and neglect on parents and children.

The Pro-Child project has been active in developing its own evaluation studies, participating in other research studies, and cooperating with the National Evaluation of the Joint Demonstration Projects.

Three studies have been undertaken by project staff to evaluate the effectiveness of their program. The first was an assessment of the developmental progress of children in the day care program. The second was an evaluation of other agencies' perceptions of Pro-Child's success as measured by questionnaires distributed to personnel of the agencies represented on the Advisory Board. The third was a pilot project for a follow up study of client's perception of Pro-Child's services.

Pro-Child staff and many clients have participated in six other research studies carried out by other evaluators in the nearby vicinity. These studies were assessing such variables as the social isolation of Pro-Child clients, the protection and nurturing abilities of people with abuse and neglect problems, age and impulse control, interaction patterns of family members, empathy and role modeling techniques, and pre-test of an innovative interviewing method.

In addition to these research activities, the project has cooperated fully in the National Evaluation. Close to 100% of the BPA forms have been completed and the staff have been extremely conscientious in completing all other tasks for this evaluation.

Conclusion

A. When a federally funded project is incorporated into an already existing program, it is essential to have the support and ongoing approval of the agency's administration for the operation and continuance of the program.

Recommendation

1. Agency administrators should be an integral part of the initial planning and approval process.

2. Agency administrators should be involved in ongoing program planning.

3. If a program is to be continued beyond the federal funding period, planning should be done with the approval of agency administration to seek other funding sources.

Conclusion

B. Sudden termination of federal funding makes for a difficult transition of program funding.

Recommendation

1. Federal funds should be gradually withdrawn over a period of time to allow local and state governments and other funding sources to gradually supplement federal funds.

Conclusion

C. Financial assistance selectively used and readily accessible is often an important factor in relieving stressful situations.

Recommendation

1. A protective services program should have an emergency fund which is administered apart from the total agency budget.

Conclusion

D. The protective services workers who have the job of doing the initial investigation of cases of abuse and neglect are subject to a high degree of pressure due to the demanding nature of their job. Programs should consider the stressful nature of this work in planning.

Recommendation

1. Have sufficient workers to balance the workload. Manageable distribution is at least three intake workers to 5 ongoing workers.

2. In planning the work schedule, allow blocks of time when the worker is not assigned duty to allow for catching up on work and relief from pressure of new cases.

Conclusion

E. Support staff such as case aides and homemakers is essential to maintaining a full range of supportive services such as transportation, babysitting, help in home management.

Recommendation

1. There should be at least one support staff member for every 4 social workers.

2. The support staff should be an integral part of the staff, physically located with the rest of the staff.

Conclusion

F. Protective service workers need to be available to provide immediate response and intensive services to clients when needed.

Recommendation

1. Caseloads should be no more then 20 families per worker.

Conclusion

G. Professional and community education is an ongoing process.

Recommendation

1. Regular periodic educational and training sessions should be scheduled to educate the professional and lay community on the problem of child abuse/neglect and on the services available to help with this problem.

Conclusion

H. Child abuse is a complex problem, needing a variety of viewpoints in making decisions regarding case management.

Recommendation

1. Psychiatric, psychological, social work, legal, educational, and medical consultation should be readily available.

Conclusion

I. Child protection work is demanding and causes physical and emotional strain and a high rate of "burn out" in protective services workers.

Recommendation

1. Workers should be encouraged to pursue and develop their own particular professional interests.

2. Workers should be involved in a variety of tasks in addition to direct work with clients.

3. The agency should provide opportunities for staff development and in service training.

4. Opportunities should be provided to encourage peer interaction, consultation and support.

5. Supervision should be supportive with the aim of relieving stress as much as possible.

Conclusion

J. Medical services are an essential part of the protective services program, both for emergencies and for ongoing consultation.

Recommendation

1. A nurse should be assigned full time and housed with the protective services staff.

Consultation

K. Community education and a Volunteer Program are an important time consuming aspect of a protective services program.

Recommendation

1. The staff member responsible for community education and the volunteer program should be free from casework and other administrative responsibilities that do not relate to these aspects of the program.

REFERENCES

Pro-Child: A Child Abuse and Neglect Demonstration Project

Narrative Description and Progress Report - Submitted on 2/28/75 by Julia Kanwit

Narrative Description and Progress Report - Submitted on 2/28/76 by Cynthia K. Raga

Case Study - First Year - Berkeley Planning Associates

Progress Report - July 1976 - Berkeley Planning Associates

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TREATMENT AND PREVENTION

A look at some of Virginia's best and brightest programs

As we promised in the spring issue of VCPN, we've spent the last few months traveling across the state gathering information about multidiscipline direct services for child protection. This issue will be reporting on three areas that are about as diverse as any Virginia has to offer: Norfolk city, a sprawling urban area with a large transient population; Buckingham County, a poor, very rural section of central Virginia; and Arlington County, an affluent suburb of Washington, D.C., with many ethnic minorities. We've found that the programs in these areas are coping with some of the same challenges: How to find the funds to continue essential services, how to motivate a geographically or socially isolated population, how to adapt treatment and prevention techniques to the cultural complexities of a particular community. Yet these three programs have had their important successes, and the common threads running through all of them seem to be the multidiscipline spirit of cooperation, the rapport of the frontline workers with their clients and the unflagging persistence of all in reaching out to help those in need.

NORFOLK - PROJECT P.E.A.C.E.

Parent Education and Child Enrichment (P.E.A.C.E.) is sponsored jointly by Family Service/Travelers Aid (FS/TA) of Norfolk and the city's Public Health Department. Its main goal is to prevent child abuse and neglect by helping young, high-risk mothers acquire parenting skills and develop self-esteem while at the same time exposing their preschool children to an enrichment program for developing motor, language and social skills.

Social worker Marjorie Bottimore, Director of Professional Services at FS/TA and coordinator of P.E.A.C.E., traced the beginnings of the program for us. Says Bottimore: "East Ocean View is an area of the city that reflects many of Norfolk's social and physical ills--drug traffic, prostitution, low incomes, no recreation facilities, inadequate public transportation. What's more it attracts many of the transient military families who can't afford to live anywhere else. One of our social workers had been talking to some Ocean View mothers who felt terribly isolated. She learned that they were afraid of their neighbors, that they didn't have anyone to talk to and they didn't know what to expect of their children. She wanted to set up a "coffee group" for the mothers of East Ocean View to get together for discussion and general self-help while baby-sitting would be provided for their kids. That idea was the germ for P.E.A.C.E."

In May 1975 the pilot group got its formal start under the co-leadership of a social worker and a public health nurse. It was launched on a shoestring budget in two bare rooms in a Baptist church in East Ocean View. At first the mothers felt

very awkward and had little to say, but soon they began to discover common interests and common worries. By the end of the summer of 1975, the group was such a success that there were 17 mothers on the waiting list.

With the accomplishments of the pilot group as ammunition, the advocates of the new prevention plan were able to convince the Norfolk City Council to give them $23,000 in federal revenue sharing funds to operate for a year. So in October 1976 Project P.E.A.C.E was officially begun with establishment of six open-ended parent groups and concurrent children's groups as the goal. It has been a cooperative effort all the way. The chief sources of referrals are the Protective Services unit of the city's Department of Social Services and the Public Health Department. The Family Service/Traveler's Aid staff act as administrators and consultants. An advisory committee for the project draws from the departments of Health and Social Services, the Old Dominion University Child Study Center and other organizations knowledgeable about early childhood development. The Public Health nurses volunteer an invaluable amount of time, and other volunteers have been recruited among local women's groups and college students.

An important objective for P.E.A.C.E's parent groups has been to expose the members--seven or eight per group--to a variety of educational experiences, including audio-visual and handout materials, communication skills, role-playing, didactic teaching and values clarification, to help them improve their own self-image and learn to guide and discipline their children more effectively. In the child enrichment groups, serving 10 to 14 children each, kids are given the Denver Developmental Screening Test. Then an individual program is planned to suit each child's needs--activities that will develop fine and gross motor skills, language and personal-social skills.

Enthusiasm for P.E.A.C.E. among its sponsors runs high, but the project has not been without its problems. They had conducted a widespread campaign to publicize P.E.A.C.E., which turned up a number of self-referrals. But, according to Marjorie Bottimore and Lu Ella Howard, coordinator of the city's Protective Services unit, they had more trouble recruiting and holding members than the pilot group experienced. Says Bottimore, "We soon learned that we had to do a tremendous amount of groundwork." Protective Services' role is to select the right candidates for this kind of group learning experience, letting them know in a low-key way that there is help. Then one of the group leaders visits the mother and tells her about P.E.A.C.E.. Since group membership is not compulsory, an empathetic first contact with the leader is key, stress Bottimore and Howard; the mother will be alienated from the start if she feels the worker is too critical of her situation. "Even then," says Bottimore, "We have to keep at them, get them motivated."

Another on-going issue has been how to recruit and use volunteers successfully. Volunteers were felt to be essential to the children's enrichment program--ideally one to every two children. But it takes a long time to train them, and many, particularly the students, aren't with P.E.A.C.E. that long. The best experience they've had with volunteers, says Bottimore, is in the pilot group. The Suburban Women's Club has been a consistent and effective source of volunteer help. In addition, the project has two male students who relate beautifully to the children. Generally, however, the volunteer program has been disappointing, and there are plans to hire four full-time staff, funded by C.E.T.A., as a substitute for the students.

What about the successes of Project P.E.A.C.E? VCPN collected the comments of the administrators, the group leaders and the parents and came up with some big plusses. Lu Ella Howard of Protective Services says, "We know that the program itself has cut down on the man hours required by our social workers. Parents participating in P.E.A.C.E. are put in a 'monitoring' category, meaning we don't need to make regular visits as long as they continue to attend." Another measure of the program's effectiveness, says Bottimore, is the parent groups. Several have "fanned out." The mothers socialize and help each other outside the meetings by baby-sitting or lending things to each other.

Group leaders also have many positive experiences to relate. For instance, despite the nomadic population, group cohesiveness is good. It may take four or five months for a group to really work well together, but once people start coming on a regular basis, much can be accomplished. New members are welcomed by the old members. One of the leaders said: "They feel so good about what's happening to them, that they want to help a new member in the same way." Lu Ella Howard adds, "The program has been a success because of the personalities of the group leaders. They are enthusiastic, and very human, and this comes through. We have often heard a client exclaim after a group leader's first visit,'I didn't know she would be like that!'"

None of the mothers we talked to want the groups to end; they aren't ready to cut the apron strings. They constantly take the lessons learned in group dynamics out into their world--in discussions with their friends, in

dealing with their husbands. One member said that while her Navy husband was on sea duty, she taped all the sessions and made him sit down and listen to them when he got home!

About the lasting influences of Project P.E.A.C.E. one mother had this to say, "We disagree a lot and we trade some pretty strong language, but we can handle it. I think the most important thing we are doing is learning to break the patterns of how we were raised. I can change, I know. I don't have to scream and beat my kids just because I was screamed at and beaten. And I get along with my own mother a lot better now!"

A big question for P.E.A.C.E. administrators has been where to get the money to continue operations after October of this year. They've talked up their needs all around Tidewater Virginia, an area that is known for its active and generous community service, but they still haven't gotten a firm commitment from any group. Another possibility, which looked more hopeful as VCPN went to press, is Title XX funds. They are just now finishing up the paper work. Bottimore is very encouraged, "We feel that our simultaneous parent-child work is a necessary thing and that the multi-pronged effort will have a much more lasting effect than prevention programs that reach only part of the family."

BUCKINGHAM COUNTY- CHILD ADVOCACY TEAM

The Buckingham County Child Advocacy Team is a direct-service multidiscipline team serving a sparsely settled, 585-square mile area in central Virginia. Buckingham's population of 11,500 is relatively stable and in-bred. The major employer is the pulpwood industry; the second largest occupation, farming. In 1975 the annual per capita income was $3,088--lowest of the 136 counties and cities in the state. That's one of the reasons why the Office of Economic Opportunity had chosen Buckingham in 1970 as the site of one of its rural health centers. The services offered by the Central Virginia Health Center are both essential and inseparable from the treatment goals of the Child Advocacy Team. The Center, which has 16,000 registered patients, also serves Fluvanna and Cumberland counties. Because the area is underdeveloped and the people so spread out, outreach is key to treating medical, emotional and mental ills, including child abuse and neglect. The Health Center has set up four mobile units to serve the three counties. One day a week the mobile unit has the services of a pediatrician. Each unit is headed by a nurse practitioner and staffed by four or five family health workers, one of whom has been getting special training in child welfare and child protection.

The Child Advocacy Team has met monthly since July 1976 to discuss new cases and up-date old ones; there are currently 42 cases (37 Protective Service, the rest foster care) in the active file, all monitored by Protective Service worker Gordon Ragland, who is also coordinator of the Advocacy Team. Besides Ragland, the team includes a pediatrician, a home economist from the County Home Extension Services, several nurse practitioners, a

clinical psychologist, an elementary school principal, the juvenile probation officer and a public health nurse. As Ragland says, "Our team represents all the resources in Buckingham County; if it's not in the team, the county doesn't have it. The real benefit of this type of team is the instant referral."

Members have unqualified praise for each other's professional and personal qualities. When VCPN sat in on a meeting, we were struck by how no one dominated the discussion. Whoever has established the best rapport with the client has primary responsibility for a case. A client may use any one of the team members as a "therapist." The members, in turn, will then consult with Dr. Jean Jones, head of Crossroads Mental Health Services.

Another important quality of this team and its back-up staff is its commitment to the area. Jean Jones recently moved from Charlottesville, where the cultural opportunities are clearly greater, to be nearer to her clients and the Health Center. Gordon Ragland, born and reared in Buckingham, came back after college and five years in the Navy. "I'll probably stay here forever; it's my home," he says. All the family health workers are local people who know their clients personally.

What problems do the team members encounter? The distance clients have to travel to the Center is a big factor. The therapists at the mental health agency don't go out to the satellite units, so clients have to be transported, sometimes many miles, to every appointment. Says Ragland, "Six visits would be considered a success; we can't get long-term treatment programs going in an isolated area like this." For the same reason, group therapy is practically out of the question; the logistics are just too complex.

How do team members cope with "woodshed" philosophies of rearing children? It is not uncommon for a parent to look upon beating with a razor strap as a perfectly acceptable form of discipline. Thus, both Ragland and the others who have much of the home contact with clients must tread lightly. In order to be effective they have to avoid being too quick to judge while still exposing these parents to less harsh methods of teaching a child.

For the most part it's the cooperative spirit of the team members that add up to success in Buckingham County. Ragland says, "I don't think anyone is jealous of their information; we share everything." He cites his working relationship with the juvenile probation officer as an example. In families with runaway and truant children, both workers do a lot of preventive intervention. The probation officer may have a good therapeutic relationship with the parents, while the Protective Service worker does more counseling with the child.

During our visit we met a young mother of two who has been followed closely by Gordon Ragland and the Advocacy Team. "Before I got help," she says, "I felt like I didn't want to live anymore." Her youngest child developed severe respiratory problems soon after she was born, and the mother was instructed in how to use special monitoring equipment. In the middle of one of the severest winters on record, with almost no money for food or utilities and a husband who gave her little emotional support, Vepco threatened to cut off her electricity. It was then that the team went into action. They helped her apply for Medicaid and food stamps and interceded with the utility company. At this point she began to confide in Lynn Pool, one of the team's nurse practitioners. Now that the baby is out of danger she has even been able to take a job in a local garment factory. The way she speaks of Lynn Pool is a credit to the flexibility and supportiveness of Buckingham's Child Advocacy Team. "I can call Ms. Pool anytime I need her, and sometimes even when I don't need her she comes."

ARLINGTON COUNTY– PRO-CHILD

So much publicity has surrounded the innovations of Pro-Child that we were curious to see first-hand how it lived up to its reputation. It is one of the 11 demonstration projects funded by HEW for three years beginning in May 1974 to offer a full complement of services to abusive and neglecting families. Pro-Child is the name given to the Protective Services unit of Arlington's Department of Human Resources, which serves this small (26 square miles) affluent Washington suburb of 174,000 people. In 1970 only 4% of the families fell below a poverty income level. The county has a considerable military population and large numbers of foreign nationals--about 8% of the school population speaks English as a second language. Before 1974 responsibility for serving clients with child abuse and neglect problems fell to several agencies working relatively independently--the Protective Services unit, the police and the Juvenile and Domestic Relations Court. Since then, Pro-Child has become the focus of the child abuse and neglect system, ensuring consistency of handling and providing a link with other community agencies.

As a result of the demonstration grant, Pro-Child was able to increase its staff from seven to 14 and acquire the consultation services of a psychiatrist, a psychologist and a lawyer. The services available through Pro-

Child include multidisciplinary team review, individual, couples, and group therapy and counseling, an alcoholic therapy group, psychological testing, day-care and therapy groups for children, five emergency shelter homes and homemaker services.

Programs for children have been especially comprehensive. WAY was a sorely needed two-days-a-week crisis nursery discontinued in March for lack of funds and noncompliance with state day-care licensing standards. Other services include two groups for play therapy, one for art therapy, one for latency-aged children with destructive behavior and one for predelinquent adolescents.

Pro-Child Administrators feel that their efforts to involve volunteers have been very fruitful. Marcia Moss, Pro-Child director since August 1976, has particular praise for student volunteers: "Our students are fantastic. Many are working with individual families as 'big brothers' and 'big sisters.' Most come to us through the University of Virginia, and Madison and George Mason colleges. They have been getting course credit and might even come to a multidiscipline team meeting if we are staffing a family they're working with." This year Pro-Child's volunteer program received one of five awards made by the state Office of Volunteerism.

Because of the project's heavy caseload--almost 600 families in 1976--the multidiscipline team confines itself to reviewing particularly severe or problematic cases in their monthly meetings. Thus, the case consultation that goes on outside the meetings is considerable. One good working relationship for Pro-Child is with pediatrician Dr. Marjorie Hughes, chief of School Health Services in Arlington. Dr. Hughes has been on the MD team since September 1973. "Before Protective Services came into being," she says, "we had to go to court and charge a criminal action." So when Pro-Child surfaced a few years ago, school personnel welcomed them. "In some ways," says Hughes, "the school system over-used Pro-Child; we made referrals too fast! So we worked out a protocol: If a child appears at school with signs of abuse, he is sent to the principal or the school nurse. Then I, or the school nurse examine him before Pro-Child is contacted.

Another issue, which is unique to Arlington, is its large ethnic population. Dr. Hughes is articulate about the difficulties presented to Pro-Child: "When the Vietnamese started an influx in the early 1970's, we had to learn to deal with some strange superstitions and practices that could be interpreted as child abuse or neglect in our terms. For example, Hughes says, the classic problem was accidents resulting from leaving, say, a 5-year-old in charge of a two-year-old while both parents were at work. "Though we've had to learn the emigrant's cultural idiosyncracies," she says, "we've also had to tell them what is acceptable in America."

Some of the innovative services of Pro-Child have helped to combat these cultural differences. One of the mothers' therapy groups is designed to meet the needs of Pro-Child's 20-plus Spanish-speaking families. Run jointly by two Spanish-speaking caseworkers, the group had its first meeting in January of this year. Said group leader Sadie Jenkins: "The seven mothers in the Spanish-speaking group have many parenting problems in common. Their children are immature by our standards. They are isolated, and the kids, who usually speak English better than their parents, can get out of control." One mother we talked to seemed so shy that we asked Jenkins about her. "You should have seen her four months ago! She barely spoke and then only in two- or three-word answers. She would even put a sweater over her face when the others asked her a question. She's come a long way since then." This young mother had made a special request to meet us; she wanted to let us know in person how much the group had helped.

The most moving testimony of the benefits of the project's group therapy program was our interview with one Pro-Child mother and her 16-year-old daughter. The mother, who had recently "graduated" from her therapy group, is an outspoken advocate of the Pro-Child philosophy: "Three years ago a caseworker came to my front door and said I'd been recommended for a group of mothers who couldn't cope with their children. My reaction was, 'I don't care what you ask, I'm not going to tell you anything!' It didn't take long,though. In a few weeks I really started having fun." This is a woman who had tried everything else--her minister, a mental health clinic--nothing had helped. She had been involved with the courts since 1964; most of her seven children were in foster care. Now, three years later, all her kids except the married ones are back home. She says, "If it had not been for Pro-Child, I don't think my family would be together today."

Her teen-ager reiterates her mother's comments. Two years ago, she says, she had been having major problems in school, and had even stopped attending most of the time. At first she refused to attend group therapy; then she wouldn't get involved in the discussion. But, gradually, she began to set some goals for herself--stop arguing with Mom, stop getting into fights, go to school. Now that she has met these goals, she, too, will be graduating from the group.

VIRGINIA CHILD PROTECTION NEWSLETTER
DIVISION OF SOCIAL WORK
CENTER FOR CHILD ABUSE EDUCATION
UNIVERSITY OF VIRGINIA MEDICAL CENTER
BOX 223
CHARLOTTESVILLE, VIRGINIA 22901

Nonprofit Organization
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Address Correction Requested

With the capacity to provide intensive services to families, the project reduced the percentage of children placed in foster care from 5% of the total Protective Services caseload in fiscal year 1975 to 2.9% in fiscal year 1976. At the same time, children who require foster care and are referred for placement by Pro-Child remain in care an average of 3.1 months, compared to a one-year average for children referred for placement from other sources. These figures seem to show that Pro-Child's intensive work with children and their families has cut down on the time spent in foster care. This obviously pays dividends in other ways. Director Marcia Moss claims: "We figure that we saved the State of Virginia and Arlington County almost $100,000 last year by keeping children out of foster care and residential treatment programs."

Because of these impressive figures the project's future is not as bleak as it might be with federal support now at an end. The county budget for the next fiscal year includes money to pay for some of the positions lost by the federal grant. Clearly, however, there will have to be some reorganization of the present program. Marcia Moss believes that they will lose many of their support services: "We will only have one case aide, where we used to have two. There will be less money for transportation, which will affect the therapy groups. Caseloads will go up--from a manageable 28 per worker. And we will be doing more crisis work and less prevention."

Newsletters & other publications

-- We'd like to spread the word about two free, exceptionally good newsletters:

Response is published bimonthly by the Center for Women Policy Studies and funded by the Law Enforcement Assistance Administration. Its full title, "Response to Intrafamily Violence and Sexual Assault," gives you an idea of the subject matter covered. Recent issues have featured articles on meeting the needs of battered women, workshops for training rape counselors, the dynamics of incestuous families and techniques for dealing with the child victim/witness in a molestation case. Though funding to continue publication after this month is up in the air, you can still be put on the mailing list or receive back issues by writing to CWPS, 2000 P Street, N.W., Suite 508, Washington, D.C. 20036.

If you don't already receive AWARE, the newsletter put out by the Virginia Commission for Children and Youth, get on their mailing list right away by writing to VCCY, Ninth Street Office Bldg., Suite 901, Richmond, Va. 23219. AWARE is an invaluable monthly source of information on the status of programs and legislation affecting children. The spring issues included a useful summary of the recent Juvenile Code revisions and articles on volunteerism, foster care and subsidized adoption, plus an explanation of the powers and responsibilities of the new Division for Children, which will replace VCCY in July 1978.

--The 1976 Annual Report of Alliance--Child Abuse Coordination Program, Diane Erene, Director, 1654 W. Onondaga St., Syracuse, N.Y. 13201; Price: $1. This is a comprehensive, informative outline of the child protection program in Onondaga County, which uses the multidiscipline team approach complimented by well-trained parent aides to work intensively with high-risk families. Basic to their treatment plan is the theory that parents must be the focus of all planning and, therefore, should be involved in most team meetings. This unique practice, says the program's advocates, not only saves a lot of time, but holds both the family and professionals accountable for their participation in the on-going treatment plan.

--What Everyone Should Know About Child Abuse; Channing L. Bete Co., Inc., 45 Federal St., Greenfield, Mass. 01301. Price: 25 cents. Here's a little booklet ideal for use in physicians' and dentists' waiting rooms and as a handout at parent group meetings and teacher training sessions. It defines child abuse and neglect in all its forms, explains why parents abuse their children and gives reasons why everyone should get involved in helping to solve the problems that cause abuse. There are also tips to use in identification, the kinds of help available and the steps to follow when you suspect a case of abuse or neglect.

Fresh solutions found for child abuse and neglect

By Lucia Mouat
Staff correspondent of
The Christian Science Monitor

Arlington, Virginia

New thrust for Arlington County, Virginia: prevention rather than law-enforcement

There was a time when Marjorie Hughes used to think long and hard before taking a case of suspected child abuse or neglect to court.

To be sure, the Arlington County School health division chief had seen plenty of school age youngsters whose bodies were burned by cigarettes, bruised, and whipped and many more cases of children ailing because their parents neglected them.

The problem was that in the early days of her 20 years service with the county, the courts were almost the only route to action in such cases. Yet charges were often impossible to prove, and the parents could often hit back with a court suit of their own.

Despite the difficulties, Dr. Hughes, feeling a strong obligation to the children involved, did take a number of cases to court. She recalls one instance of six children (four of them in school) who showed obvious signs of family neglect by their clothes, health, and eating habits. While Dr. Hughes did succeed in getting all the youngsters assigned to temporary foster care, the mother happened to be mentally retarded and the case was thrown out of court.

"I couldn't prove criminal neglect – and I was also mildly afraid that some lawyer would get to the father and I'd be sued," she says.

Fewer court cases

Since these days, however, protection for abused and neglected children in Virginia has undergone several major changes for the better, and Dr. Hughes could not be more pleased. She says that although more cases are handled than ever before, fewer end up in court and fewer result in transferring youngsters to foster homes.

What has happened in many Virginia counties including Arlington, is that the Welfare Department has set up a child protection service with a preventative rather than a law-enforcement thrust.

"Involving the police right away (as many school systems do) would be fine if all these cases were out and out obvious – but many of them are 'iffy,'" says Dr. Hughes. "It's important to get at the reasons behind what happens. Sometimes they're good ones. These aren't all cases of just plain mean old parents – besides, we're not so much out to point blame as to find a solution.

An added plus in Arlington County has been the success of a three-year federally funded experiment known as "Pro-child," one of 10 such child-abuse programs around the country financed by a Department of Health, Education, and Welfare grant. With its staff of social workers and case aides and its access to consulting services of lawyers and psychiatrists, Pro-child handles more than 300 cases a year. It offers everything from consulting help to parents and teen-agers who feel in conflict with one another to a nursery where mothers can leave their children when they feel upset about something during the day. Pro-child, whose funding is due to run out in June, has had a homemaker on the staff who even can go in and help set a home in physical order if the need is central to a problem of child abuse or neglect.

In many Arlington families the mother is the only parent and often the sole source of family income, says Dr. Hughes, and problems sometimes result from the fact that "she occasionally gets a little overwhelmed and needs someone to boost her up."

New law helpful

A new 18-month-old law, Dr. Hughes explains, is another strong aid for Virginia school and health authorities who want to give children the protection they deserve.

Not only does the law require the county welfare department be told of anything looking suspiciously like abuse or neglect, but it specifically names those responsible for the reporting. Included on that list are health, law enforcement, and social workers as well as teachers (nursery and day-care among them) and Christian Science practitioners. While all those reporting are immune from civil or criminal liability unless malicious intent can be proved, they are liable to fines (as much as $500 for a first offense) if found guilty of failing to report a case needing attention.

Dr. Hughes terms it a "super law" and says it has not changed established school procedures for handling such cases all that much – "it's just made them a lot easier to follow because of the added protection."

What happens then in Arlington when a teacher or a nurse (as is often the case in the course of health exams) spots a case of suspected abuse or neglect?

How to proceed

It must be reported to both the nurse and the principal of the school so that some verification can be made. Then the child is subject to a second observation – "either the nursing supervisor goes or I go," says Dr. Hughes, who has also been doubling as the consulting pediatrician on the Pro-child program. With the added protection of the new law, school and health authorities are free to chat with the child about the problem and the results can be informative. Dr. Hughes, for instance, recalls chatting with a third grader about a bruise on the side of his head. The child said his father had done it the night before but confided with a grin: "Boy, was I asking for it!" In that case school authorities took no action and to their knowledge the child experienced no further trouble.

"If it's the first time, we don't make a referral unless it's really bad – any parent is allowed once to lose control," says Dr. Hughes, who adds, "as a parent I know I can get furious with my own kids."

If a first incident is serious, however, or if it is the second time around, it would be reported and the school nurse would go to the home and talk with the parents.

"That puts them on warning, and we also want to hear what they have to say," explains Dr. Hughes.

Occasionally, cases still go to court.

Child neglect

In Arlington, instances of child neglect far outnumber those of actual physical abuse, she says.

"When our parents get mad, they're not as likely to lash out and beat the tar out of their children as they might in the inner city. . . . Instead they might just physically or psychologically leave. . . . It's just a different way of dealing with their frustrations."

Reasons for neglect vary from parental preoccupation with jobs and other activities ("We're following one case where the mother is manager of a pornographic movie house and the child just isn't getting the kind of care he needs," says Dr. Hughes) to cultural factors. Some children from Korean families, for instance, are left home unattended while parents are working, while some school-age Pakistani girls have been purposely kept home to take care of younger children in the family.

"All these things worry us because they're a form of neglect," says Dr. Hughes, who points out that the triggering sign for a watching teacher is thus not always the dramatic black and blue mark but such subtler things as children not dressed for coping with the weather (minus socks and coat for instance), who are habitually absent from school, or who are having behavioral or academic problems.

3

Christian Science Monitor 4/11/72

21

THE WAY: A CRISIS NURSERY

I. Overview

The WAY is a crisis nursery sponsored by Pro-Child - a child abuse and neglect demonstration project funded by HEW and Arlington County Va: through the Social Services Division of the Department of Human Resources. The WAY program has two purposes: 1) To give temporary relief to parents in crises by providing a day-care facility for those children whose families are involved with Pro-Child; and, 2) To offer these children stimulating and socializing experiences designed to help offset the effects of the crisis situation in their homes. The program also strives to involve parents in the operation of the nursery in those instances where such involvement is indicated in the treatment plan for the family.

Pro-Child, in conjunction with Clarendon United Methodist Church, submits the following proposal for the continuation of the WAY program for the school year of 1975 - 1976.

II. Procedure

The WAY will operate as a temporary facility for 15 to 20 children (ages 2-6) from 9:00 a.m. to 4:00 p.m. on Tuesdays and Thursdays. The facility will be located in the Clarendon United Methodist Church at 6th and North Irving Street, Arlington Virginia. The Church will contribute the necessary space and outdoors equipment for the operation of the program.

The program director of the church and a Pro-Child advisory board member will assume responsibility for hiring and managing the WAY staff.

Pro-Child will be responsible for staff salaries, supplies, additional equipment and transportation for the program.

Pro-Child staff will refer children to the program on a daily basis and will provide the following information on each child: name, address, phone number, medical data, signed releases, any other pertinent information on the child.

The WAY staff will keep a detailed record on each child which will be shared with the Pro-Child worker.

The church will submit a monthly statement to Pro-Child including the name of each child in attendance, his date of participation and fee for previously authorize monthly expenses (see budget information on Page 2)

III. Program

The director will be responsible for developing the program content. The program will include a combination of group and individual activities, primarily recreational but well-structured in implementation.

Special socialization needs such as toilet training, peer group relations and behavioral problems will be dealt with on an individual basis by WAY staff.

Parental involvement will be managed on a case to case basis with collaboration between the Pro-Child worker, the church program director and the WAY staff.

The director will be responsible for planning daily activities, task assignments and record keeping. The WAY director will primarily report to the church program director for administrative supervision.

The staff will consist of two full-time aides, one aide being from the Pro-Child staff. The aides will assist in the transporting of children to and from the program, follow through on the director's agenda and assist in recording their observations of the children at the end of each day. Pro-Child mothers who do not have children eligible for the program will be considered as applicants for the aide positions.

Volunteers will be used as aides to insure a 5:1 ratio of staff to children.

The director will conduct regular staff meetings for the purposes of evaluating, activity planning and the recording of observations on each child. The Pro-Child staff will be kept informed of each child's progress.

V. Transportation

Transportation will be provided by Pro-Child. A bus and driver from the Departme of Human Resources will be assigned to pick up the children and return them home. One aide will be on the bus to assist the driver. Payment will be made directly to DHR from Pro-Child funds.

VI. Budget

September 1975 through April 1976.

The following figures are based on an average of 8 days per month for 8 months. The program will not be held on Thanksgiving, Christmas or New Year's day.

The following items will be billed monthly:

1.	Salaries		
	Director	$400/month	$3,200/yr.
	Aide	200/month	$1,600/yr.
	Social Security	35/month	$ 280/yr.
	Subtotal	$635/month	$5,080/yr.
2.	Supplies		
	Cookies, Milk, Juice	$80/month	640/yr.
3.	Transportation		
	Bus and Driver	$160/month	$1,280/yr.
	3hrs. per day $5/hr plus 25¢/mile		
	Total	$875/month	$7,000/yr.

4. Other special expenses include additional play equipment, cots and insurance. Pro-Child will attempt to secure the equipment and cots as contributions from the community.

The Way

The Way Program

The Way Program is a nursery operated by the Pro-Child Unit in the Division of Social Services for children ages 2-5.

The nursery operates on Tuesdays and Thursdays of each week from 9:00 a.m. to 5:00 p.m. Transportation is provided by Pro-Child.

The nursery is located at Clarendon United Methodist Church, 6th and North Irving Streets, Arlington, Virginia - Phone: 527-3814

A Day at Way

8:30 - 10:30	Pick up Period*
10:30 - 11:00	Morning Activities (a) Opening exercise (b) Creative period - includes art, crafts, roleplaying, etc.
11:00 - 12:00	Playground Activities (a) Free Play (b) Supervised group games
12:00 - 12:30	Lunch
12:30 - 1:00	Storytelling and Nap Preparation
1:00 - 2:00	Nap (all children are encouraged to take a nap or just relax quietly)
2:00 - 2:45	Afternoon Activities (a) Free Play in or out doors (b) Individual games
2:45 - 3:00	Snack Time
3:00 - 3:00	Free Play and Preparation for Departure
3:15 - 5:00	Transportation Home

*Children engaged in free play while others are being transported

Way Special Activities

On April 29, 1976, The Way children and Staff took a very exciting bus ride to Oxon Hill Children's Farm in Oxon Hill, Maryland.

The children were thrilled at seeing the farm animals and patting and playing with many of them. Most of the children had never seen the chickens, ducks, cows, goats, sheep, horses, pigs and other animals found on a farm.

The farm equipment enticed many of the boys and they were eager to climb aboard the wagons and inspect the plows and other farming tools.

Everyone left there delighted, after having a fun day in the country.

****

Again on June 3, 1976, the children and Way staff happily loaded the "Big Bus" and journeyed to the National Zoo in Washington, D. C.

The elephants, hippos, lions, bears, apes, etc. all seemed huge to the children. They were amazed at the size and observed them with eyes wide open.

The small animals, mainly the monkeys, captured the childrens' full attention.

This was a day truly enjoyed by all.

Upcoming Events

- Trip to Animal Farm, Reston, Virginia

- Trip to Storybook Land

- Openhouse

* Time and Date of these events will be given later.

Parent Participation

All parents who are interested in doing volunteer work at the Way shoud contact their Social Worker.

Pick Up and Delivery of Children

In the mornings, parents are requested to have their child ready when the Way station wagon arrives. Please bring the child to the car and assist with loading your child.

When your child is returned in the afternoon, we request that you come out to meet him or her.

IMPORTANT !!!!!!

Please call Pro-Child, 558-2613, when your child is not going to Way or when you are going to carry your child to the Way program.

Try to call before 8:30 a.m. on the day of pick up.

THOUGHT OF THE MONTH

"Children Learn What They Live"

- If a child lives with criticism,
  He learns to condem.

- If a child lives with hostility,
  He learns to fight.

- If a child lives with ridicule,
  He learns to be shy.

- If a child lives with shame,
  He learns to feel guilty.

- If a child lives with tolerance,
  He learns to be patient.

- If a child lives with encouragement,
  He learns confidence.

- If a child lives with praise,
  He learns to appreciate.

- If a child lives with fairness,
  He learns justice.

- If a child lives with security,
  He learns to have faith,

- If a child lives with approval,
  He learns to like himself.

- If a child lives with acceptance and friendship,
  He learns to find love in the world.

STAFF

Judy Smith - Director

Barbara Gieman - Aide

Peggy Sykes - Pro-Child Worker

Virginia Taylor - Pro-Child Worker

VOLUNTEERS

Lucy Sweeney, Ann Fowley, Hanna Fowley

ARLINGTON COUNTY, VIRGINIA
DEPARTMENT OF HUMAN RESOURCES
SOCIAL SERVICES DIVISION
2300 South Ninth Street
POB 4310, Arlington, Virginia 22204

HELEN HACKMAN, M.D., M.P.H.
DIRECTOR

BARBARA GLASER
DIVISION CHIEF

Letter of Transmittal

The attached questionnaire concerned with services rendered to you, is part of a self-study being conducted by Pro-Child to determine its effectiveness in the community. We are especially interested in your ideas because we feel that you as the recipients are most aware of where the inadequacies may be.

All answers will be kept strictly confidential. Neither we, nor the agency wish to identify you in any way. We are seeking this information only for the purpose of evaluating ourselves.

We are interested only in your true feelings about our services and about Pro-Child itself, and hope that you will take the time to give thoughtful and honest answers.

Your time and cooperation as well as interest and involvement in this project has been greatly appreciated.

Valerie Irons
Valerie Irons

Teena Nichols
Teena Nichols

Marie Savoy
Marie Savoy
Research Coordinator

I. Staff's Effectiveness

1. What did or do you see as your social worker's greatest strength? _____

_____

_____

2. What did or do you see as your social worker's greatest weakness? _____

_____

_____

3. How do you feel your social worker could have been more effective in assisting you? _____

_____

_____

4. Please answer questions below with yes or no:

_____ They were understanding.

_____ They were not understanding.

_____ They were helpful.

_____ They were somewhat helpful.

_____ They were no help at all.

_____ They were available to me when I needed them.

_____ They were sometimes available.

_____ They were not available.

II. Information and Referral

1. Did your social worker provide appropriate information, resources or referral to another agency?

_____Yes

_____No

2. In what areas do you feel more information should have been provided? _____

_____

III. Concrete Services

1. Which services provided by Pro-Child did you find most helpful? _____

_____

_____

2. Which services provided by Pro-Child did you find least helpful? _____

_____

_____

3. Check below any problems you feel your family had when first contacted by our agency.

_____ Housing
_____ Medical
_____ Financial
_____ Babysitting
_____ Employment
_____ Marital
_____ School
_____ Discipline of Children
_____ Drinking
_____ Drug Use
_____ No Friends
_____ Depressed
_____ Worried
_____ Nervousness
_____ Conflict with Relatives
_____ Sexual
_____ Children in trouble with Court
_____ Other

4. Now, draw a circle around those checks for problems that you have been helped with.

5. Could your situation have been prevented or alleviated had another service or resource been provided in the community?

_____Yes

_____No

If so, what would that service have been? _____

_____

_____

6. Check below services you found most helpful.

_____Daycare/Babysitter	_____Employment
_____Foster Care	_____Individual Counseling
_____Birth Control Information	_____Family Counseling
_____Medical	_____Group Counseling
_____Child-Rearing	_____Housing
_____Homemaker	_____Transportation
_____Budgeting	_____Other
_____Education/Training	_____Received no help

IV. Client's Effectiveness

1. Has the situation you had when first contacted by Pro-Child improved?

_____Yes

_____No

2. (a). Do you feel better able to deal effectively with stress and/or an unpleasant or unhappy situation?

_____Yes

_____No

(b). In what ways?_____

_____

_____

3. (a). Should you feel under enormous stress in the future, can you reach out for help?

_____Yes

_____No

(b). Do you feel you could call Pro-Child?

_____Yes

_____No

4. Do you feel better about yourself?

_____Yes

_____No

5. (a). Has your relationship improved with your family?

_____Yes

_____No

(b). In what manner? _____

_____

_____

6. Do you find it easier to meet and get along with other people?

_____Yes

_____No

V. Research Data

1. What is your age? _____

2. Are you presently receiving services from a Pro-Child worker?

_____Yes

_____No

3. How many children are in your family? _____

4. What is your marital status?

Single never married_____

Separated _____

Married _____

Common-Law _____

Widowed _____

Divorced _____

5. What is your immediate family's income? (please circle)

a. $15,000 and over

b. $10,000 - $15,000

c. $ 5,000 - $10,000

d. under $5,000

_____Yes

_____No

7. To what racial group do you belong? _____

8. What is your educational level?_____

CASE REFERRAL GUIDELINES

I. Protective Services

A. Mandatory Reports (If child did not receive professional intervention in order to deter or treat abuse/neglect, the child would be subject to permanent physical and/or emotional damage)

1. Physical abuse
   a. Bone fractures
   b. Subdermal hematoma or hemorrhage, brain damage
   c. Intake of poisonous substances
   d. Bruises, burns, scalding, wounds, cuts
   e. Internal injuries
   f. Sprains, dislocations
   g. Choking child or attempted drowning
   h. Environmental failure to thrive
   i. Incompatibility of history with injuries found or with age of patient
   j. Previous hospitalization or emergency room visits for similar or unexplained injuries
   k. Abuse is alleged and person about whom allegation is made refuses to discuss complaint with worker
   l. Known history that parent has previously abused child, abused another child in family, or another child has died of unexplained causes
   m. Malnutrition due to deliberate withholding of food
   n. Exploitation, e.g. overwork beyond physical endurance, forced to steal, beg
   o. Child states that he is being abused and/or beaten
   p. Child subjected to bizarre punishments
   q. Parent states that he is abusing child
2. Sexual abuse
   a. Incest
   b. Molestation
   c. Exploitation
3. Neglect
   a. Food
      (1) Child is malnourished and emaciated
      (2) Withholds food as punishment
   b. Clothing
      (1) Exposed to elements due to improper clothing, shoes, etc.
      (2) Dirty, smelly, ragged, and in general disrepair
      (3) Inappropriate clothing that usually results in harassment from child's peers
   c. Shelter - sleeping arrangements
      (1) Filthy living conditions including garbage and dirt strewn about house, floors and walls smeared with feces, urine smell permeates house, vermin in house
      (2) Hazardous conditions existing for children, e.g. broken stairs, broken windows
      (3) Make-shift sleeping arrangements
   d. Supervision
      (1) Abandonment
      (2) Parent or caretaker suffers from alcoholism, criminal activity, drug addiction, or severe mental illness
      (3) Child is shuffled from one caretaker to another, e.g. left with aunt for a few days and then neighbor, etc.

(4) Child under 8 is left alone over extended period of time on a regular basis
(5) Child is locked out of house
(6) Child under 8 expected to care for younger siblings

e. Medical/health
(1) Failure to provide necessary immunizations
(2) Suffers chronic or acute illness and lacks essential medical care
(3) Severe dental neglect
(4) Does not receive necessary prosthetics, e.g. hearing aid, glasses
(5) Failure to carry out prescribed medical care, including psychiatric care
(6) Failure to provide medical attention to child who is accidentally injured

f. School
(1) Deprived of school to stay home to help parents and/or care for siblings
(2) Fails to attend school regularly due to fault of parents
(3) Failure of parent to cooperate with the school in providing remedial assistance to child

4. Emotional abuse
a. Overt rejection of child, e.g. shouted at, left alone, blamed for problems, degraded, ridiculed
b. Parent exhibits no affection or nurturing; rejected through indifference
c. Child is forced to fend for self at early age and to accept too much responsibility
d. Child is not permitted to socialize
e. Child is made to stay in bed all the time

B. High Priority
1. Physical Abuse
a. Parents known to assault one another, fear for child's safety
b. Strict disciplinary patterns resulting in potential injury
c. Overly severe control and discipline

2. Sexual
a. Exposure to parent's promiscuity and prostitution
b. Parent deters development of normal sexual identity
c. Child is victim of rape

3. Neglect
a. Food
(1) Haphazard meals
(a) Meals inconsistently lacking nutritional value
(b) Steady diet of potato chips, pop, candy, etc.
(2) Insufficient food
(3) Lack of proper diet results in anemia, listlessness
(4) Regular meals not provided, e.g. no breakfast before going to school, no lunch money

b. Clothing
(1) Insufficient clothing - inappropriate clothing for weather and temperature, no underwear, incorrectly sizes, in disrepair

c. Shelter
(1) Home condition in total chaos, no evidence of routine housekeeping
(2) Overcrowded
(3) Poor lighting, poor ventilation, fire hazards
(4) Poor sanitation as result of inadequate or unrepaired plumbing
(5) Bedding and chairs soiled

d. Supervision
   (1) Child is shuffled from one babysitter to another due to parent's poor planning
   (2) Parent/caretaker suffers from severe mental retardation
   (3) Child is left with irresponsible babysitter
   (4) Parent/caretaker sets no limits

e. Medical care/health
   (1) Child's body and hair are dirty
   (2) Child fails to receive routine dental check-ups, physical exams, and eye exams
   (3) Extensive diaper rash left unattended
   (4) Parent is ignorant of child reading practices

f. School
   (1) Child exhibits severe behavioral problems, hyperactivity, withdrawn behavior in class as result of home problems
   (2) Inability of child to form relationships with peers and teachers, e.g. child is ostracized

4. Emotional abuse/Preventive Services

Definition -

A family must indicate the potential for extreme dysfunction between parent and child such as abuse and neglect which seemingly can be prevented by the provision of intensive short-term casework services. To be eligible a family must: 1) Agree to service, 2) Be aware of referral source, e.g. family service worker explains to family the referral to Pro-Child

a. Child is described as different, being scapegoated - handicapped, always sick, seen as unattractive, "bad," slow, etc.
b. Parent feels alone - no relief or support, feels at end of rope, can't tolerate children's behavior any more, fears loss of control
c. Parent's distress - actions and/or reactions are out of proportion to child's behavior - locks active child in room, screams at child inappropriately
d. Parent shows non-response or extreme irritation toward child, e.g. child crying in background; mother feels she can't respond or can't cope
e. Parent holds unrealistic expectations for child's age; child is supposed to be mature beyond years, to look to parents' needs rather than his own
f. Child's behavior reveals visible symptoms stemming from emotional neglect e.g. fire-setting, nervous skin disorders, psychosomatic complaints, overeating, suicide attempts, stuttering, enuresis, school phobia
g. Child is overindulged, overprotected
h. Unusual circumstances surround child's birth, e.g. out-of-wedlock, birth to fill parents' needs, named after or looks like disliked relative or parent, mother denies pregnancy, child result of incest or rape
i. Parent fails to individualize child and his needs and fails to give constructive discipline for child's proper development
j. Parent has demonstrated previously her inability to care for children, e.g. placed in foster care, and needs intervention before serious problems arise with younger children

Cases Excluded from Pro-Child

1. Chronic environmental problems, e.g. inadequate housing, poor money management
2. Adolescent truancy, delinquency, school problems, sexual promiscuity, unless directly related to parents' abuse/neglect
3. Marital conflict is confined to parents and is the primary family prob

4. Chronic life situations which depend on long-term supportive casework (over 6 months)
5. Family already involved in another treatment service, e.g. private psychotherapy which is working toward the same goal in reducing high-priority complaint
6. Foster care or residential treatment is indicated and necessary

COMMUNITY STANDARDS

I. Food

1. Child shows growth and developmental patterns appropriate for age and body build.

2. Child shows no signs of physical deterioration, such as anemia, from lack of proper diet; including environmental failure to thrive.

3. Child who is in need of a special diet; e.g., child suffering from renal disease, is given this diet.

4. Child has meals regularly provided, e.g., breakfast before coming to school, lunch money, etc.

5. Parents and/or caretaker do not withhold food as "punishment".

II. Clothing

1. Child's clothing is clean, correctly sized and in good repair.

2. Child's clothing is not such that it causes him to be "stigmatized"; e.g., holes, no underwear, shoes and socks missing.

3. Child has clothing appropriate for weather conditions and temperature.

III. Shelter/Sleeping Arrangements

1. Housing facility has water, heat, electricity and security measures.

2. House is in a reasonable state of repair; e.g., screens, glass in windows.

3. Housekeeping standards are adequate; no filthy conditions, no obnoxious odors from urine, pets.

4. No more than two children sleep in the same bed; sexes are separated.

5. Child has bed in room separate from the parents.

6. Linens are provided.

IV. Proper Supervision

1. Child under eight is not left alone even for short periods during the day.

2. Child is left with a responsible babysitter (babysitter minimum age 12) during the day.

3. Child has a responsible adult or teenager to care for him at night.

4. Child is not locked out of the house when parent is home/child under five is not left unattended in yard or neighborhood.

5. Child is not shuffled from one babysitter to another.

6. Caretaker or parent does not suffer from alcoholism, drug addiction or severe mental illness.

7. Parents do not rely on young siblings to care for each other.

8. If child becomes ill at school, parent has arrangements for care of child.

V. Health

1. Child receives essential medical care for either acute or chronic illnesses.

2. Child receives dental care, immunizations, physical examinations, eye check-ups, corrective shoes, if needed.

3. Child who is professionally evaluated as needing psychotherapy, receives psychotherapy.

4. Child's personal grooming habits are good--child's body and hair are clean.

5. Parents carry out physician's, nurse's recommendations and insure follow-up medical care, including extensive diaper rash.

6. Parents secure medical attention for child if child is accidentally injured.

7. Physician's care is provided for an obese child.

VI. School

1. Child does not exhibit severe behavioral problems - hyperactivity, withdrawn behavior in class.

2. Child shows capacity to form relationships with peers and teachers.

3. Child's learning disability does not seemingly stem from home environment.

4. Parents cooperate with school officials in helping child to get special attention, tutoring, psychological evaluations, and attend conferences.

5. Child is not consistently tardy, absent (without excuses), absent (with "unlikely" excuses), or kept home to take care of younger children.

6. Child is alert in school and seems well-cared for by parents.

7. Parent does not keep child home because he wants child's company. This applies to nursery school as well - when it appears that child is in need of this experience.

VII. Exploitation and Over Work

1. Child is not subjected to incestual experiences or sexual activities.

2. Child is not deprived of school to stay home and help parents.

3. Child is not expected to regularly care for younger siblings.

4. Child is not made to do unreasonable household chores.

5. Child is not subjected to bizarre punishments.

6. Child, himself, states that he is being abused, beaten, etc.

VIII. Emotional Neglect/Abuse

1. Parents make degrading, ridiculing remarks to child.

2. Parents exhibit no affection or apparent nurturing.

3. Child is forced to fend for self at an early age - expected to take on too much responsibility.

4. Child has no toys or stimulating experiences.

5. Child is kept in the house all the time and not permitted to socialize.

6. Child is made to stay in bed all the time.

7. Child shows sign of emotional disturbance related to:

a. marital problems of parents
b. constant fighting in the home
c. mentally ill parent or parents
d. inconsistent discipline
e. over-indulgence
f. exposure to promiscuity, violence
g. alcoholic or drug-addicted parents
h. parent's being so invested in self that he can not extend self to child

Reportable Cases

If child did not receive professional intervention in order to deter or treat abuse/neglect, the child would be subject to permanent physical and/or emotional damage.

Thus, many of the sub-categories taken to the extreme would be reportable situations; e.g., food--starvation, emanciated condition. In addition, all of the following instances would be reported.

1. Incompatibility of history with injuries found or with age of patient.

2. Sexual abuse, molestation.

3. Unusual amount or type of soft tissue injury (bruises), particularly if in varying states of healing.

4. Multiple fractures with various states of healing, metaphyseal fractures.

5. Subdural hematoma in infant or young child.

6. Previous hospitalization or emergency room visits for similar or unexplained injuries.

7. Lacerations, burns, intake of poisonous substances.

8. Previous registration with Committee for Child Protection or Bureau of Vital Statistics.

9. Abuse is alleged and person about whom the allegation is made, refuses to discuss the complaint with the worker.

10. Known history that parent has previously abused child, abused another child in family or another child has died of "unexplainable" causes.